Department of Health and Human Services
Health Insurance Portability and Accountability Act of 1996 (HIPAA)
Electronic Health Care Transactions and Code Sets Complaint Submission Form

You may use this form to file a HIPAA complaint. This form is for the submission of complaints about covered entities that are not compliant with the HIPAA electronic health care transactions and code set standards. This form should not be used to file complaints regarding the privacy of health information.

You will be able to file on-line soon. Or you may mail your complaint to the following address:

HIPAA Complaint
7500 Security Blvd., C5-24-04
Baltimore, MD 21244

Section A: Your Contact Information (person or entity filing the complaint)

First Name: _____ Middle Initial: ____ Last Name: _____

Title: _____ Organization: _____

Street Address Line 1: _____

Street Address Line 2: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Extension: _____

Email Address: _____

Section B: Information about the Entity that you are filing a complaint about

Name of Covered Entity: _____

Tax Identification Number: _____ Medicare Identification Number: _____

Type of Covered Entity (Check one)

____ Health Care Clearinghouse
____ Health Plan
____ Health Care Provider (choose one)
- O *Dentist*
- O *DME Supplier*
- O *Home Health Agency*
- O *Hospice*
- O *Hospital*
- O *Nursing Home*
- O *Pharmacy*
- O *Physician/Group Practice*
- O *Other*

Covered Entity Contact Person:

First Name: _____ Middle Initial: ____ Last Name: _____

Title: _____

Street Address Line 1: _____

Street Address Line 2: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Extension: _____

Section C: Specific Complaint

Type of Complaint:

____ Transactions (check all that apply)

- O *Health claims and equivalent encounter information*
- O *Enrollment and disenrollment in a health plan*
- O *Eligibility for a health plan*
- O *Health care payment and remittance advice*
- O *Health plan premium payments*
- O *Health claim status*
- O *Referral certification and authorization*
- O *Coordination of benefits*

____ Code Sets (check all that apply)

- O *ICD-9 diagnosis*
- O *ICD-9 procedure*
- O *HCPCS*
- O *CPT-4*
- O *Dental*
- O *NDC*

Provide comments in the area below:

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